DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/22/13

PRINTED: 05/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain fire rated walls. The findings include: Observation on April 29, 2013 between 3:45 p.m. and 4:30 p.m. revealed penetrations in the following locations: 1. 100 Hall soiled work room. Above ceiling, sheet rock has detached from the head wall. 2. Fire doors by room 108. Above ceiling at corridor fire doors, fire caulk has fallen out around bundle of wires penetrating the wall. 3. 200 Hall soiled work room. Above ceiling, sheet rock has detached from the head wall.	K 017	**K 017:** **Item # 1:** **100 hall soiled workroom sheetrock repaired on 5/9/13.** **Item # 2:** **Fire caulk by room # 108 by fire doors was repaired on 5/9/13.** **Item # 3:** **Sheet rock in 200 hall soiled work room was repaired on 5/9/13.** **Item # 4:** **Galvanized pipe at fire doors by room 309 was repaired with fire caulk on 5/9/13.**	6/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William Michael Taylor
TITLE: Administrator
(X6) DATE: 5/24/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 1 4. Fire doors by room 309. Above ceiling at corridor fire doors, galvanized pipe not fire stopped. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to have corridor doors smoke resistant. The findings include:	K 018	**K 018** **100 and 300 hall doors to ice machine were repaired to meet 90 minute rating for fire doors on 5/13/13.**	6/1/13

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K 018	Continued From page 2 Observation on April 29, 2013 between 2:00 p.m. and 3:00 p.m. revealed that the 100 hall and 300 hall doors to the ice machine rooms have louvers. These doors are 90 minute fire doors that were altered to compensate for air flow to these rooms. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide lighting for exit discharge. The findings include: Observation on April 29, 2013 at 4:05 p.m. revealed the exit discharge from the 400 hall did not have egress lighting for the entire exit discharge leading up to the kitchen's walk in coolers. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 045	**K 045** **Exit lighting from 400 hall added as indicated on inspection. Lighting work was completed on 5/13/13.**	6/21/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062	**K 062** **Obstructions noted on 100; 200; 300; 400 hall clean linen storage rooms and wheel chair storage room were immediately corrected to meet required sprinkler head clearances. Indicators were placed on wall as a reference for height restriction.**	6/21/13

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K 062	Continued From page 3 continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have all sprinklers free and unobstructed. The findings include: Observation on April 29, 2013 between 1:30 p.m. and 2:35 p.m. revealed the following areas have sprinkler heads obstructed by linens and storage. 1. 100 hall clean linen storage room. 2. 200 hall clean linen storage room. 3. 300 hall clean linen storage room. 4. 400 hall clean linen storage room. 5. Wheel chair storage room boxes stacked up to sprinkler head. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	K 066 Metal containers with self-closing cover devices into which ashtrays can be emptied were immediately purchased and installed in the two (2) designated smoking as identified.	6/21/13

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K 066	Continued From page 4 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide appropriate ashtray containers. The findings include: Observation and interview with the maintenance director on April 29, 2012 between 12:00 p.m. and 2:00 p.m. revealed metal containers with self-closing cover devices into which ashtrays can by emptied, were not provided or readily available to the two (2) designated smoking areas. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	K 069 Fire sprinkler contractor notified and repairs and/or adjustments were made to extinguishing agent nozzle under the kitchen hood as identified in inspection. Repairs were completed on 5/14/13.	6/21/13

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K 069	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide proper extinguishing coverage for the appliances under the kitchen hood. The findings include: Observation on April 29, 2013 at 11:20 a.m. revealed that the extinguishing agent nozzle under the kitchen hood was positioned toward the back of the tilt skillet and not centered over the cooking appliance. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 069		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have all exit discharge free and unobstructed. The findings include: Observation on April 29, 2013 at 11:07 a.m. revealed that the exit discharge from the 400 hall by the walk in coolers was obstructed by trash	K 072	K 072 Trash cans, carts, and water hose was immediately removed from the exit discharge from the 400 hall by the walk in coolers.	6/21/13

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K 072	Continued From page 6 cans, carts, and a water hose that was stretched across the side walk. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on April 29, 2013.	K 072		

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